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Carcinoma of the Stomach*

THOMAS F. MULLEN, M.D., *San Francisco*

CANCER of the stomach poses problems of the greatest importance to all of us because of its high incidence, its rapidly fatal course unless treated in its early stages, and, especially, the general air of pessimism which surrounds the whole subject. It is the spectre at the banquet of our surgical complacency. I have elsewhere stated that doctors might well be divided into two classes: those who are forever suspicious of gastric cancer and never find it and those who are never suspicious of it and forever miss it. The former may be comforted by the fact that they have committed no sin of omission. The latter must bear that odium. It must be a distressing experience to have the diagnosis finally become obvious in a patient who has been treated symptomatically for a long period without having had a careful, searching study made to rule out this serious disease. However, this often occurs. not only adding to the problem that the surgeon is ultimately called upon to answer, but giving rise to unjust criticism of the surgical treatment, which after all is the only known method at present which offers any chance of cure.

That there are instances in which even the most careful search might fail to reveal the lesion is granted, but they are rare. In the great majority the diagnosis could be made much earlier if all of the means at our command were used with skill. The first physician to see the patient is so often the one on whom the fate of the patient rests, for if this physician—be he general practitioner, internist, gastro-enterologist or surgeon—fails to be suspicious of this disease and searching in its detection, we will continue to see late, inoperable, hopeless cases arrive and the pessimism will daily grow. A culpable attitude of pessimism is that which holds that the disease is hopeless from the beginning and, once the diagnosis is made, dismisses the problem with a warning to the patient to prepare to die. This attitude of mind will not admit that anyone was ever cured of gastric cancer by surgery, using the word "cure" in the same fashion that we use it in any other type of malignancy. This in spite of increasing evidence to the contrary. In 1941 The Registry of The American College of Surgeons had 1,249 instances of five-year cures recorded, and there must be many more that have not been mentioned.

That surgery is not the ideal answer is admitted, but not to use it is like refusing to rescue a drowning man because you have to pull him into a rowboat instead of being able to part the waves before him. All surgeons complain that the difficulties come from the extension of the process to regions outside the stomach. As a matter of fact, we usually have to treat the complications of the disease, including involvement of many other structures outside the primary site. If a cancer is treated while still confined to the stomach, the chance of long survival is great, and yet studies on autopsy material have shown that as high as 23 per cent of patients have died before any metastasis had occurred (Warwick). It is obvious that many might have been saved by early operation.

Why is the diagnosis not made earlier? Several reasons occur—the patient's indifference to mild symptoms, the careless or incomplete examination, and reliance upon one negative examination in the face of continuing symptoms. I am convinced that it is dangerous to consider gastric ulcer as anything other than a surgical lesion from the very beginning. The therapeutic test of such an ulcer may be greatly misleading unless it is interpreted with proper reservations. It is not generally understood that it is not possible to differentiate malignant from benign ulcer in a very high percentage of cases, nor is the great incidence of carcinoma appreciated. It remains a fact that the majority of

* Chairman's address, presented as part of a panel discussion on Carcinoma of the Stomach at the Seventy-fifth Annual Session of the California Medical Association, Los Angeles, May 7-10, 1946.

cases reach the surgeon months after the onset of symptoms and sometimes even after years. Many have been treated as benign ulcers or as some form of indigestion without having had the benefit of x-ray or gastroscopic investigation. Such fundamental studies as gastric analysis or a search for the causes of unexplained anemia or asthenia, or for the source of occult blood in the stool are left undone while the patient and the doctor are lulled by temporary, often empirical measures.

The extent of surgical ablation of the stomach and contiguous structures in the treatment of gastric cancer has been stretched to the limit and little more can be expected from technical refinement. It is therefore our duty to continue to press the need of recognizing the disease in its early stage and while it is still susceptible to the only means of cure that we now know—surgical removal. Too frequently, the surgeon, feeling that every patient in whom the diagnosis of cancer of the stomach is made is entitled to operation unless that course is obviously hopeless, is compelled to take heroic measures to overcome advanced disease. Too often he has to decide if he has anything to offer to make easier the final days in a battle that was lost before he entered the field. It is therefore our duty constantly to remind the one who first sees the patient to be eternally suspicious and thorough in his search for gastric cancer in all patients who have mild digestive symptoms.

450 Sutter Street, San Francisco.

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What Can the Internist Do to Get More Early Cases Of Carcinoma of the Stomach to the Surgeon?*

CLAYTON D. MOTE, M.D., *San Francisco*

A MALE patient, 52 years of age, entered the hospital with the complaint of vomiting for one month, abdominal pain for three months and a weight loss of 25 pounds during the previous six months.

He had been perfeetly well until two years before entry into the hospital when he first began to notice some vague epigastric distress following meals and a distaste for certain foods, particularly meat. He noted mild relief of his symptoms for several months with various self-prescribed medications directed to relieve his "acid indigestion," but for a month before entry he had had a great deal of vomiting and abdominal pain. His weight had gradually declined from 175 pounds to 150 pounds.

Physical examination revealed a man showing signs of some recent weight loss. Nothing else of significance was noted until the abdomen was examined. An indefinite mass could be palpated in the epigastrium. The liver edge was easily felt beneath the right costal margin. The liver was slightly larger than usual and the edge felt hard and somewhat lumpy. Digital examination of the rectum revealed a hard, fixed, non-tender mass in the cul-de-sac which was tvpical of a rectal shelf. A large filling defect involving the lower half of his stomach was seen on x-ray examination, and there was also a moderate degree of pyloric obstruction with some retention of the barium meal. Achlorhydria and low total acid was present on gastric analysis and the fasting content contained occult blood. The diagnosis of carcinoma of the stomach at this stage was relatively obvious, and in the presence of metastases in the peritoneum and liver, the lesion was considered inoperable.

DELAY IN DIAGNOSIS

It is a sad commentary that about one-half of the patients with carcinoma of the stomach when admitted to hospitals in the United States are considered inoperable. Better therapeutic results and a change in the pessimistic viewpoint shared by most of us can hardly be expected while such a situation exists. However, the purpose of this discussion is not what must be done to educate patients so that they seek assistance early in the course of the disease, but rather to emphasize certain factors that will aid the doctor in early recognition of the lesion. The doctor many times is slow in making a diagnosis, and too often several months go by before the gravity of the situation is realized. The diagnosis of carcinoma of the stomach is not always easy and at times the combined efforts of the doctor, radiologist, gastroscopist and surgeon must wait for the last word to come from the pathologist as to whether the lesion is benign or malignant.

The onset of the disease is often abrupt. The symptoms of anorexia and gastric distress make their appearance in a patient who previously had been entirely free of gastro-intestinal symptoms. It is in this group of patients with symptoms that we can hope for earlier recognition of the lesion.

* Presented as part of a panel discussion on Carcinoma of the Stomach at the Seventy-fifth Annual Session of the California Medical Association, Los Angeles, May 7-10, 1946.